

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18241

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

18254

1. DECEASED-NAME (Type or print) <b>WILLIAM WRIGHTSON BLUNT SR.</b>			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>23</b> Year <b>1968</b>			2b. HOUR <b>6:15 PM</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUG. 6 - 1894</b>		6. AGE (In years lost birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS <b>74</b> DAYS <b>74</b> HOURS <b>74</b> MIN.			
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>QUEEN ANNE</b> Md.					
10. CITY OR TOWN OF DEATH <b>GRASONVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>XX</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>G.A. GRASONVILLE</b>			13c. CITY OR TOWN <b>XX</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>XX</b>	
14. FATHER'S NAME First <b>NOAH</b> Middle <b>BLUNT</b> Last <b>BLUNT</b>			15. MOTHER'S MAIDEN NAME First <b>MOLLIE</b> Middle <b>QUILLEN</b> Last <b>QUILLEN</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO. <b>220-28-0772</b>			17. INFORMANT Address <b>MARGARET BLUNT-GRASONVILLE</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>492X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>5 years</b> <b>5 yrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>5271</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>63</b> , to <b>Dec</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-10-1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>John R. Smith Jr.</b>			DEGREE <b>MD.</b>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-26-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>JOHN R. SMITH JR.</b>			22e. ADDRESS <b>CENTREVILLE MARYLAND</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>DEC. 27</b>		23c. NAME OF CEMETERY OR CREMATORY <b>WOODLAWN</b>			23d. LOCATION (City or Town) (County) (State) <b>EASTON MARYLAND</b>			
24. FUNERAL DIRECTOR <b>Edgar L. Lane - CHURCH HILL MD.</b>			ADDRESS			25. REG. BY REGISTRAR <b>DEC 31 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

1872

March

1872

At the Court of Sessions at New York City

in the case of

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18242

18255

1. DECEASED-NAME (Type or Print) <b>George Thomas Hadrick</b>			2a. DATE KNOWN OF DEATH Month <b>12</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>10:20 P.M.</b>		
3. SEX <b>Male</b>	4. RACE <b>Negro</b>	5. DATE OF BIRTH <b>4/16/51</b>	6. AGE (in years last birthday) <b>17</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month <b>12</b> Day <b>18</b> Year <b>1968</b>		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne</b> Md.		
10. CITY OR TOWN OF DEATH <b>Open Highway</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Route 301</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Student (H.S.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b> COUNTY <b>Queen Anne</b>		13b. CITY OR TOWN <b>Grasonville</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD Grasonville, Md.</b>		
14. FATHER'S NAME First <b>Joseph S.</b> Middle <b>S.</b> Last <b>Hadrick</b>			15. MOTHER'S MAIDEN NAME First <b>Shirley</b> Middle <b>Hutchinson</b> Last <b>Hutchinson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT ADDRESS <b>Joseph Hadrick Grasonville, Maryland</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Third degree burns with marked charring of entire body</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <b>auto accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>8224</b>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>10:20 P.M. 12/18/68</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Car skidded, tipped over &amp; caught fire</b>				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Highway</b>		21f. LOCATION Street or R.F.D. No. City or Town County State <b>U.S. 301 Queenstown Queen Anne's Md.</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>C. Rodney Layton</b>		EXAMINER'S NAME (Type) <b>Dr. C. Rodney Layton</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>12/21/68</b>		
				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
				ADDRESS (Street, city, town, or county) <b>Centreville, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>12/21/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bryans Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Grasonville Queen Anne Md.</b>		
24. FUNERAL DIRECTOR <b>J. B. Dashiell Funeral Home Barbara L. Dashiell</b>				25a. REC'D BY REGISTRAR <b>DEC 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

233-1

STATE OF TEXAS

COUNTY OF DALLAS

FILE NO. 100-100000

IN RE: [illegible]

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BOOK 2-220

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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18243

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

18256

1. DECEASED-NAME (Type or Print) <b>Edwin C. Halsey</b>			2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> Month <b>12</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>8<sup>th</sup></b> M			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>3/11/1884</b>	6. AGE (In years last birthday) <b>84</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b>	DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b>	MIN <b>0</b>	2c. DATE PRONOUNCED DEAD <b>12</b> Month <b>10</b> Day <b>68</b> Year <b>19</b>	2d. HOUR <b>10<sup>th</sup></b> M
7a. BIRTHPLACE (State or foreign country) <b>N.J.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne's County</b> Md.			
10. CITY OR TOWN OF DEATH <b>Ingleside, Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Ingleside, Md.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Retired - Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Ingleside Md.</b>			13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Ingleside</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>None</b>		
14. FATHER'S NAME <b>John Rensley Halsey</b>			15. MOTHER'S MAIDEN NAME <b>Sarah Ferris</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>49-03-4432</b>		17. INFORMANT ADDRESS <b>Wife - Mrs. Edwin Halsey</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Occlusion</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4109</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 mins</b> <b>10 year</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>John R. Smith Jr.</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED <b>Dec. 10, 1968</b>			
EXAMINER'S NAME (Type) <b>John R. Smith, Jr., M.D.</b>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
			ADDRESS (Street, city, town, or county) <b>Centreville, Md. 21617</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>12-13-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Templeville</b>		23d. LOCATION (City or Town) (County) (State) <b>Templeville, Maryland</b>			
24. FUNERAL DIRECTOR <b>J. E. Boulaie's Greenlboro, Md.</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>DEC 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)  
30M REV. 1/64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

18214

CERTIFICATE OF DEATH

18257

1. DECEASED-NAME (Type or print)		First <b>Edith</b>		Middle <b>Park</b>		Last <b>Harrison</b>		2a. DATE OF DEATH Month <b>December</b> Day <b>25</b> Year <b>1968</b>			2b. HOUR <b>3:30 PM</b>		
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>February, 20, 1890</b>			6. AGE (In years last birthday) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne's</b> Md.							
10. CITY OR TOWN OF DEATH <b>Crumpton</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>----</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>School Teacher Ret.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Elem. School</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>O.A.Co.</b>		13c. CITY OR TOWN <b>Crumpton</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>none</b>				
14. FATHER'S NAME First <b>George</b> Middle <b>I.</b> Last <b>Harrison</b>			15. MOTHER'S MAIDEN NAME First <b>Emma</b> Middle <b>Cowley</b> Last <b>Cowley</b>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>214-36-5540</b>		17. INFORMANT Address <b>Miss, Anna C. Harrison, Crumpton, Md. 21828</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4129</b> IMMEDIATE CAUSE (a) <b>Acute Corbore Pulmonary</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Chronic myocardial</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Grand Arterial Sclerosis</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4221</b> <b>Stroke</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION <b>---</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour <b>6:00</b> A.M. Month <b>10</b> Day <b>19</b> Year <b>1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. <b>---</b> City or Town <b>---</b> County <b>---</b> State <b>---</b>									
22a. I certify that (I) (this hospital) attended the deceased from <b>Dec 24, 1968</b> , to <b>Dec 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>Dec 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <b>C.H. Metcalfe</b>								DEGREE <b>MD.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12/27/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>C.H. Metcalfe, M.D.</b>								22e. ADDRESS <b>Sudlersville, Md. 21668</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Dec. 28, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Crumpton Cemetery.</b>			23d. LOCATION (City or Town) (County) (State) <b>Crumpton, Q.A. Md.</b>						
24. FUNERAL DIRECTOR ADDRESS <b>Edward Fellows &amp; Son, Millington, Md. 21651</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-44  
30M REV. 1/78

18245

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

18258

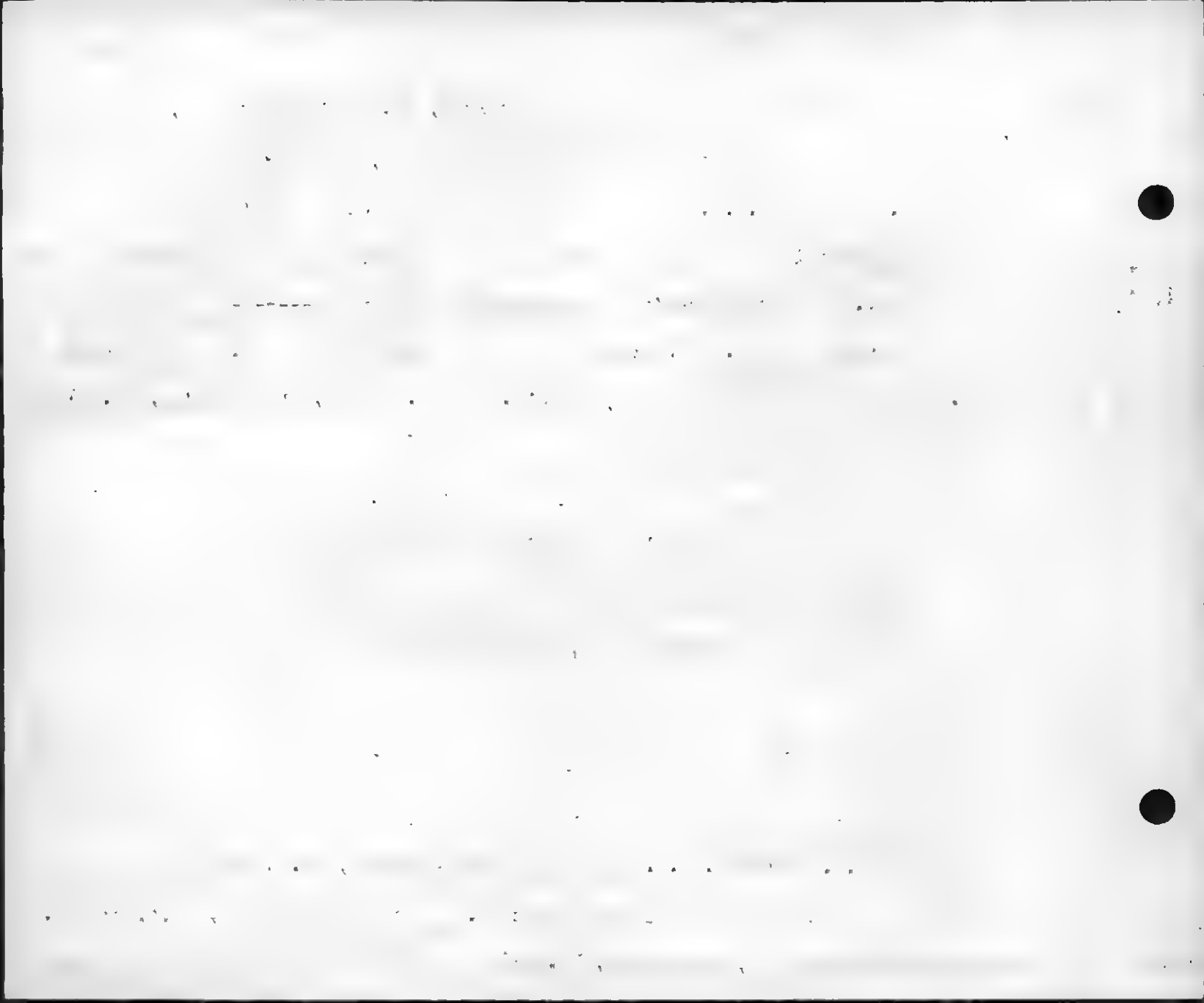
1. DECEASED-NAME (Type or print) First Middle Last <b>Grover C. Milbourn</b>			2a. DATE OF DEATH Month Day Year <b>December 4, 1968</b>			2b. HOUR M <b></b>					
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July, 28, 1886</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Queen Anne's Md.</b>					
10. CITY OR TOWN OF DEATH <b>Sudlersville</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Ret. Clerk</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Gen. Store.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Queen Anne's</b>		13c. CITY OR TOWN <b>Sudlersville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>		
14. FATHER'S NAME First Middle Last <b>Richard Milbourn</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah Peterson</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No.</b>			16b. SOCIAL SECURITY NO. <b>220-16-7670</b>		17. INFORMANT <b>Mr. Kenneth Smith, 215 Lotus St; Dover, Del.</b>			Address <b>19901</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Dehydration</u> 4129 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Myocarditis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Atherosclerosis</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4221 <u>Stroke</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION <b>24</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year <b>10 P.M. 19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>200</b>			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 1960</u> to <u>Dec 4, 1968</u> , that (I) (we) last saw the deceased alive on <u>Dec 1, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>C.H. Metcalfe</u>						22c. DATE SIGNED <u>12/5/68</u>					
22d. PHYSICIAN'S NAME (Type) <b>C.H. Metcalfe. M.D.</b>						22e. ADDRESS <b>Sudlersville, Md. 21668</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>Dec. 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sudlersville Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Sudlersville, Q.A. Md.</b>			
24. FUNERAL DIRECTOR <b>Edward Fellows &amp; Son, Millington, Md. 21651</b>						25a. REC'D BY REGISTRAR DATE <b>DEC 9 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

18246		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		18259	
Item 5 Film 407 12/20/68 kk		CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH	
Joseph Pearson, Jr.				December 10, 1968	
3 SEX	4. RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS
Male	White	February 23, 1911		58 YRS.	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
Del.		U.S.A.		9. COUNTY OF DEATH Queen Anne's Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	
Rural Sudlersville		None		Janitor Leads Travel Ware	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN RD	
Md.		Queen Anne's		Sudlersville	
14. FATHER'S NAME First Middle Last		15. MOTHER'S MAIDEN NAME First Middle Last		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	
Joseph E. Pearson		Mary F. Embert		No.	
16b. SOCIAL SECURITY NO		17 INFORMANT		Address Rural	
		Mrs. Mary F. Pearson, Sudlersville, Md. 21668			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis</u>					
(b) <u>Chronic Myocarditis</u>					
(c) <u>Acute &amp; Chronic Alcoholism</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerosis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Dec 4, 1968, to Dec 12, 1968, that (I) (we) last saw the deceased alive on Dec 6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type) C.H. Metcalfe, M.D.		22e. ADDRESS		22f. ADDRESS	
		Sudlersville, Md. 21668			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		12/12/68		Holdens Cemetery.	
23d. LOCATION (City or Town) (County) (State)		23e. LOCATION (City or Town) (County) (State)		23f. LOCATION (City or Town) (County) (State)	
Rural Sudlersville, Q.A.Co; Md.		Rural Sudlersville, Q.A.Co; Md.		Rural Sudlersville, Q.A.Co; Md.	
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR	
Edward Fellows & Son, Millington, Md. 21651				DATE DEC 16 1968	
				25b. REGISTRAR'S SIGNATURE	
				Charles Judge	



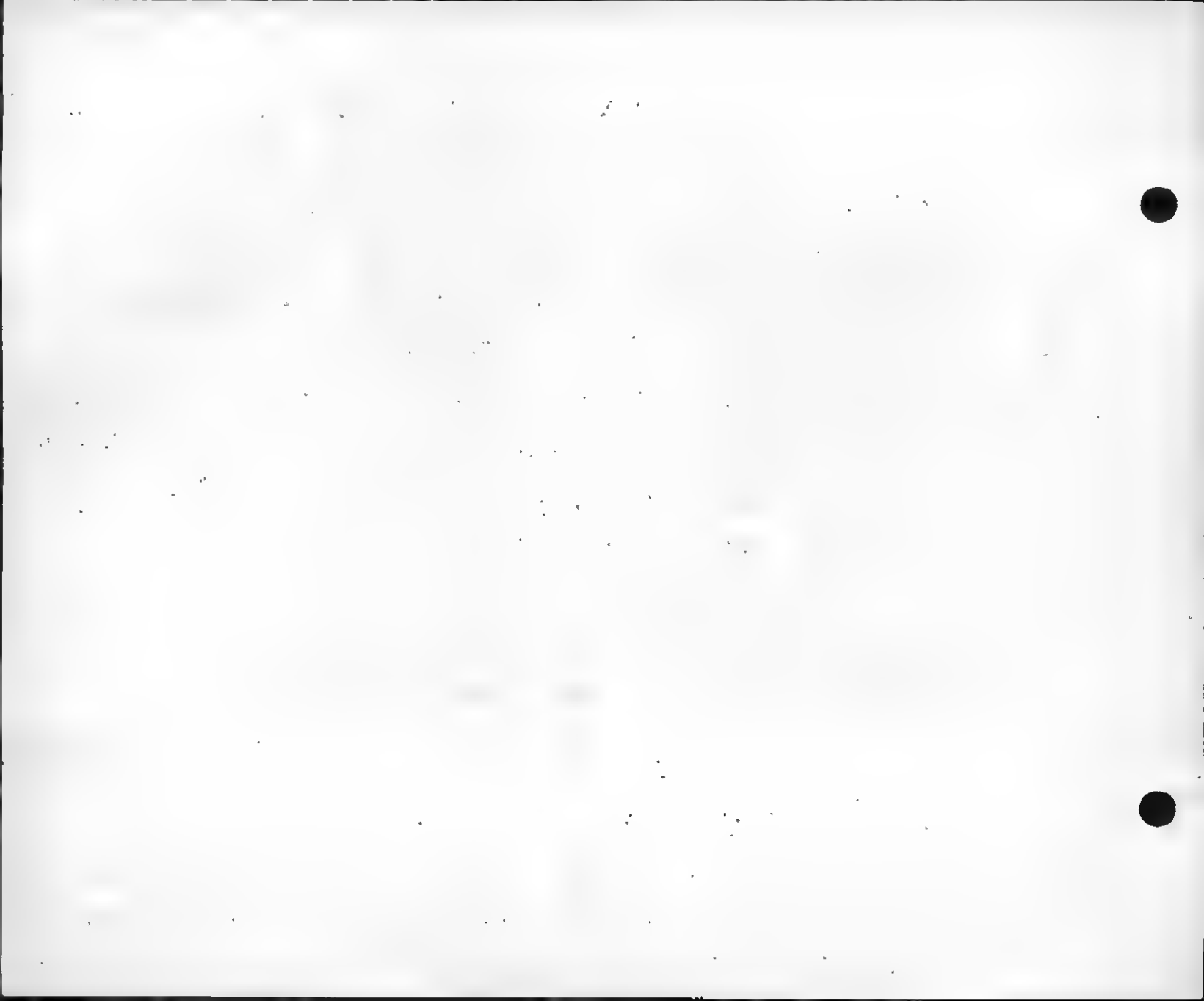
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 154  
30M REV. 1-68

18217										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18260																			
1. DECEASED-NAME (Type or print)										2a. DATE OF DEATH										2b. HOUR																			
First Middle Last										Month Day Year										HOURS MIN.																			
R HYNSON ROGERS										Dec. 20, 1968										12:36 P.M.																			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (n years lost birthday)			IF UNDER 1 YEAR			IF UNDER 24 HRS.																								
Male			white			July 3, 1880			88 YRS			MONTHS DAYS HOURS MIN.			MONTHS DAYS HOURS MIN.																								
7a BIRTHPLACE (State or foreign country)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH																														
Maryland			USA						Queen Anne						Md																								
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY																														
Sudlersville			Kitty's Nursing Home			Retired Lawyer																																	
13a USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET AND NUMBER																											
Maryland			Kent			Chestertown						211 N. Water St.																											
14 FATHER'S NAME First Middle Last					15 MOTHER'S MAIDEN NAME First Middle Last																																		
Edward I. Rogers					Marianne Hynson																																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or (unknown) (If yes give war or dates of service)					16b SOCIAL SECURITY NO.					17 INFORMANT Address					Chestertown Md.																								
no					216 38 9427					Mrs. Julia Power Rogers																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										3 months																													
41200 DUE TO, OR AS A CONSEQUENCE OF										5 years																													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										2 years																													
(b) Arteriosclerotic Heart Disease, Nephrosclerosis																																							
(c) Cerebral Thromboses multiple																																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																							
19a DATE OF OPERATION										19b CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>																			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>										21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)										21f. LOCATION Street or R.F.D. No. City or Town County State																			
22a I certify that (I) (this hospital) attended the deceased from Nov. 23, 1967, to Dec. 20, 1968, that (I) (we) last saw the deceased alive on 12-13-1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																							
22b. SIGNATURE										DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22c DATE SIGNED 12/20/68																			
John R. Smith Jr.																																							
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																													
John R. Smith, Md.D.										Centreville Maryland																													
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE										23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)									
Burial										12/22/68										St. Paul Cemetery near Chestertown, Md.																			
24 FUNERAL DIRECTOR										ADDRESS										25a. REC'D BY REGISTRAR DATE										25b. REGISTRAR'S SIGNATURE									
J. Wells Wells										Chestertown, Md.										DEC 23 1968										Chesapeake Index									

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VA 11-11-68  
30M REV. 11-68

18248										DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										18261																																							
1. DECEASED-NAME (Type or print)										First Middle Last										2a. DATE OF DEATH										2b. HOUR																													
Helen										Taylor										December										1, 1968										7:27																			
3. SEX										4. RACE										5. DATE OF BIRTH										6. AGE (In years last birthday)										IF UNDER 1 YEAR MONTHS DAYS										IF UNDER 24 HRS. HOURS MIN									
FEMALE										WHITE										11/1/1899										69 YRS.																													
7a. BIRTHPLACE (State or foreign country)										7b. CITIZEN OF WHAT COUNTRY?										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. COUNTY OF DEATH																				Md.									
Czechoslovakia										Czechoslovakia																				QUEEN ANN																													
10. CITY OR TOWN OF DEATH										11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)										12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)										12b. KIND OF BUSINESS OR INDUSTRY																													
QUEENSTOWN										QUEENSTOWN, Md										Charles																																							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)										13b. COUNTY										13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET AND NUMBER																			
MD.										Queen Ann										Queenstown										YES										Queenstown, Md.																			
14. FATHER'S NAME										15. MOTHER'S MAIDEN NAME																																																	
Unknown										Unknown																																																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown										16b. SOCIAL SECURITY NO.										17. INFORMANT										Address																													
No										219-03-7581										Mrs. Marie Thompson										2035 Astor St.																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																																																											
PART 1. DEATH WAS CAUSED BY:										IMMEDIATE CAUSE (a)										DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
4109										Acute Myocardial Infarction										1 Day																																							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										(b)										Arteriosclerotic Cardiovascular Disease, Remote																																							
										(c)																																																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																																											
4201																																																											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?																													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)																																							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f. LOCATION Street or R.F.D. No. City or Town County State																																							
22a. I certify that (I) (this hospital) attended the deceased from 4-10, 1968, to 12-2, 1968, that (I) (we) last saw the deceased alive on 12-1, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																																																											
22b. SIGNATURE										22c. DATE SIGNED																																																	
Charles L. Stevens										12-2-68																																																	
22d. PHYSICIAN'S NAME (Type)										22e. ADDRESS																																																	
23a. BURIAL, CREMATION, REMOVAL (Specify)										23b. DATE										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION (City or Town) (County) (State)																													
Burial										12/4/68										Green Lawn Cem.										Queen Anne's County																													
24. FUNERAL DIRECTOR										ADDRESS										25. RECEIVED BY REGISTRAR										25b. REGISTRAR'S SIGNATURE																													
Charles L. Stevens Funeral Home, Inc.										1501 East Fort Avenue										DEC 4 1968										Charles Jones																													

MEDICAL CERTIFICATION

1. The first of the series of experiments was conducted on January 10, 1900.

The results of the experiment were as follows:

The first of the series of experiments was conducted on January 10, 1900.

The results of the experiment were as follows:

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The results of the experiment were as follows:

The first of the series of experiments was conducted on January 10, 1900.

The results of the experiment were as follows:

## CERTIFICATE OF DEATH

18249

18262

1. DECEASED-NAME (Type or print) <b>ALFRED ARTHUR WATSON</b>			2a. DATE OF DEATH Month <b>DECEMBER</b> Day <b>29</b> Year <b>68</b>			2b. HOUR <b>5A</b> M.		
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JUNE 25-1904</b>		6. AGE (In years last birthday) <b>64</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>WASHINGTON</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>QUEEN ANNE</b> Md.		
10. CITY OR TOWN OF DEATH <b>GRASONVILLE</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>XX</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>MAINTENANCE - GAS &amp; ELEC.</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>Q.A.</b>			13c. CITY OR TOWN <b>STEVENSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>XX</b>	
14. FATHER'S NAME First Middle Last <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>MRS. ANNA MAY WATSON - STEVENSVILLE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4201</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min Remote</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <b>8-5-68</b> , 19 <b>68</b> , to <b>12-29</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>12-22</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>12-30-68</b>		
22d. PHYSICIAN'S NAME (Type) <b>RALPH E. LIBBY</b>				22e. ADDRESS <b>GRASONVILLE MD.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>DEC. 31</b>		23c. NAME OF CEMETERY OR CREMATORY <b>STEVENSVILLE</b>		23d. LOCATION (City or Town) (County) (State) <b>STEVENSVILLE MD.</b>		
24. FUNERAL DIRECTOR <b>Edgar L. Lane - Church Hill Mt.</b>				25a. REC'D BY REGISTRAR <b>JAN 6 1969</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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